Mountain Peak Dental

PATIENT INFORMATION

Date___________

Name_______________________________________ Married___ Single___ Minor ___ Sex F M

Address____________________________________ City_________________ State_____ Zip________

Birthdate__________________ Soc. Sec #________________________

Home phn#________________ Work phn#________________ Cell phn #______________ Email ___________________

Employer___________________________________ Address ____

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE

Name_______________________________________ Married___ Single___ Minor ___ Sex F M

Address____________________________________ City_________________ State_____ Zip________

Birthdate__________________ Soc. Sec #________________________

Home phn #________________ Work phn #_______________Cell phn # _______________ Email___________________

Employer___________________________________ Address____

PLEASE CIRCLE PREFERED METHOD OF CONTACT: PHONE TEXT OR EMAIL

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due in full at each appointment. ___Cash ___Check ___Credit card ___ Care Credit___ I wish to discuss the office payment policy.

Whom may we thank for referring you?____

Person to contact in emergency ___________________________Relationship __________Address_________________

Home #___________________________ Cell #____________________

PRIMARY INSURED	SECONDARY INSURED
Name________________ Birthdate_____________	Name________________ Birthdate_____________
Relation to Pt__________ SS#__________________	Relation to Pt__________ SS#__________________
Employer_____________ Ins Co ________________	Employer_____________ Ins Co ________________
Group # ______________ ID # __________________	Group # ______________ ID # __________________

AUTHORIZATION AND RELEASE

I authorize payment directly to Mountain Peak Dental otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I authorize Mountain Peak Dental to administer such medications and perform x-rays, study models, photographs, and other diagnostic aids. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

The information on this form and the dental and medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

Signature____ Date_____________________

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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Form S500

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) — Yes No DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: ______________ If yes, have you had any complications? ____________________

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Date Treatment began: ______________________________

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? ______________________
If yes, how much do you typically drink i n a week? ______________________

WOMEN ONLY Are you:
Pregnant? ☐ ☐ ☐
Number of weeks: ______________
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics ______	☐	☐	☐
Aspirin ______	☐	☐	☐
Penicillin or other antibiotics ______	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ______	☐	☐	☐
Sulfa drugs ______	☐	☐	☐
Codeine or other narcotics ______	☐	☐	☐
Metals ______	☐	☐	☐
Latex (rubber) ______	☐	☐	☐
Iodine ______	☐	☐	☐
Hay fever/seasonal ______	☐	☐	☐
Animals ______	☐	☐	☐
Food ______	☐	☐	☐
Other ______	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion (If yes, date: ______)	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders (If yes, specify: ______)	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders (Specify: ______)	☐	☐	☐
Recurrent Infections (Type of infection: ______)	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:
Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: ______________________________

Mountain Peak Dental

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____

For Office Use Only

____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Financial Policy and Agreement

Thank you for choosing Mountain Peak Dental. Our primary Mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Mountain Peak Dental requires payment prior to the completion of your treatment.

- Cash, Check, Visa, Mastercard, or Discover Card
- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check at the time of service.
- CareCredit Monthly Payment Plan options allow you to pay overtime with no annual fees or pre-payment penalties. Subject to credit approval

Dental Insurance:

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill for reimbursement for your treatment.

- **It is important for you to understand that your contract with an insurance company is between you and them; therefore, the ultimate responsibly for payment rests with you. If payment from your insurance is not received from your carrier within 30 days, you will be responsible for payment.**

Late Payments/Failure to pay:

- We reserve the right to charge interest on any account 30 days and older, in the amount of 2% monthly (22% annually).
- If your account is delinquent more than 120 days, it will be turned over to a collection agency. This will take place after you receive a final collection notice from our office and no arrangements are made to settle your account. All third-party collection costs will be your responsibility.
- Default of this financial policy will result in collection action at which time the applicant will be responsible to pay all costs of collection including reasonable interest, reasonable attorney's fees (whether a lawsuit is filled) and reasonable collection agency fees in the amount of 50% of the balance due.

****A fee of $50.00 is charged to patients who miss or cancel appointments with less than 24 hours' notice****

I have read and understand Mountain Peak Dental's Financial Policy and Agreement.

X ______________________________

Signature of Patient or Responsible Party

Date: ____